MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12821

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
P. H. Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED?
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 307 1/2 E. Locust St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Fred Thomas Adkins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife: Irma Parsons
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Jan. 6 - 1914

8. AGE: Years	Months	Days	If less than one day
31	11	19	...hrs. ...min.

9. Birthplace: Parsonburg Md.
(Town, county, and state)
10. Usual occupation: Roofer
11. Industry or business: Shore Mutual Company

FATHER
12. Name: Thomas Adkins
13. Birthplace: Walston Md.

MOTHER
14. Maiden name: Ella Davis
15. Birthplace: Wango Md.

16. Informant: Mrs. Ella Adkins
Address: 307 1/2 E. Locust St. Salisbury Md.

17. Buried
(Burial, cremation, or removal. Which?)
Date thereof: Dec. 29 - 45
(month) (day) (year)
Cemetery or crematory: Bethel Cem.
Location: Walston Maryland.

18. Funeral director: Holloway & C. Della R. Holloway
Address: Salisbury Md.

19. 12/29/45 Harriet E. Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 27th 1945, at 11 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 27 1945 to Report 1945
and that I last saw h... alive on ...1945

Immediate cause of death	DURATION
Shock	
Due to: Crushed Chest	
Due to: Automobile accident	
Other conditions: Compound fracture Left femur	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 12-27-45
Where did injury occur? Westminster (City or town) Howard (County) Md. (State)
Injured at home, farm, industry, public place (where?): Public Place
Means of injury: Automobile accident Injured at work? no.

23. SIGNATURE: Oliver T. Fiedler M.D.
M. D. or other
Address: Salisbury, Md. Date signed 12-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Wanner

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17a)

CERTIFICATE OF DEATH

12822

Reg. Diat. No. 339

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred: P.S. Hoyt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 703 E. College ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: W. Leland Adkins

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Florence Adkins
6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): Nov. 5-1906

8. AGE:

Years	Months	Days	If less than one day
39	1	19	hrs. min.

9. Birthplace: Worcester Co. Md.
(Town, county, and state)
10. Usual occupation: Truck Farmer and
11. Industry or business: Produce Buyer

FATHER
12. Name: John B. Adkins
13. Birthplace: Worcester Co. Md.

MOTHER
14. Maiden name: Cordelia Esham
15. Birthplace: Worcester Co. Md.

16. Informant: Mrs. Florence Adkins
Address: 703 E. College ave Salisbury Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Dec. 26-45 (month) (day) (year)
Cemetery or crematory: Fruitland Cem.
Location: Fruitland Maryland
19. Funeral director: Holloway & E. Walter P. Holloway
Address: Salisbury Maryland.

19. (Date rec'd by registrar) 12/26/1945 Maurice E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 24 1945 at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 20 1945 to Dec 24 1945
and that I last saw him alive on Dec 24 1945

Immediate cause of death	DURATION
Gastric Hemorrhage	4 days
Due to	
Due to	
Other conditions: Gastric Ulcer	3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date at
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Wanner M.D.
M. D. or other
Address: Salisbury Md. Date signed: 12/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

12823

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico

County: Salisbury

City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred: 111 Cherry Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newly born infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No.: 637 William St. Ext (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Charles E. Ayers

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of husband or wife: Cora B. Ayers

B.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): June — 1877

8. AGE: Years 68 Months 6 Days — If less than one day: hrs. min.

9. Birthplace: Girdletree Maryland (Town, county, and state)

10. Usual occupation: retired Merchant

11. Industry or business:

FATHER — 12. Name: John J. Ayers

13. Birthplace: Worcester Co. Md.

MOTHER — 14. Maiden name: Ella Bell

15. Birthplace: Worcester Co. Md.

16. Informant: Mrs. Cora B. Ayers

Address: 637 William St. Ext Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 24-1945 (month) (day) (year)

Cemetery or crematory: Parsons Cem

Location: Salisbury Maryland

18. Funeral director: J. C. Walter R. Tilghman

Address: Salisbury Maryland.

19. 12/22/45 (Date rec'd by registrar) Charles E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 22nd 19 45 at 2 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-10-45 19 to 12-22-45 19 and that I last saw h alive on 12-21-45 19

Immediate cause of death: Apoplexy — DURATION: 12 hr.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Dr. Alla Fields M. D. or other

Address: Salisbury Md Date signed: 12-22-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

12824

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93a

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Fruitland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 Years

Hospital, Institution, or street address where death occurred: Hayward Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Fruitland (If outside city or town limits, write RURAL and give nearest town)

Street No.: Hayward Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Annie B. Bozman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Robert A. Bozman

6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): Nov. 8, 1888

8. AGE: Years	Months	Days	If less than one day
57	I	22	...hrs. ...min.

8. Birthplace: Pocomoke City, Md (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER — 12. Name: John W. Watson

FATHER — 13. Birthplace: Pocomoke City, Md

MOTHER — 14. Maiden name: Virginia Stewart

MOTHER — 15. Birthplace: Pocomoke City, Md

18. Informant: Robert A. Bozman

Address: Fruitland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 / 1 / 46 (month) (day) (year)

Cemetery or crematory: Allen Cemetery

Location: Allen, Md

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Md

19. 1/1/46 (Date rec'd by registrar) Harriet E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 30 19 45 at 1105 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 20 19 45 to Dec 31 19 45 and that I last saw h... alive on Dec 23 19 45

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Thos A. Dailey M. D. or other

Address: Salisbury Md Date signed: 1-2-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

12825

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Mr. Robert Bozman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Eva Price Bozman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 6, 1879

8. AGE: Years	Months	Days	If less than one day
66			hrs. min.

9. Birthplace: Monie Somerset Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Truck Farming

FATHER 12. Name: Isaac J. Bozman

13. Birthplace: Monie Md

MOTHER 14. Maiden name: Adeline Wallace

15. Birthplace: Champ Md.

16. Informant: Isaac Bozman

Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?), Date thereof Dec 26, 1945 (month) (day) (year)

Cemetery or crematory: Mount

Location: Near Princess Anne Md.

18. Funeral director: Dale Dashiell

Address: Princess Anne Md.

19. 12/26/45 (Date rec'd by registrar) 19 45 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 22nd 1945, at 1:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/7 1945, to 12/22 1945

and that I last saw him alive on 12/22 1945

Immediate cause of death	DURATION
Uraemia	3 days
Due to	
Due to	
Other conditions: Coronary Thrombosis	5 days

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Chas T. Gordon M.D.
M. D. or other

Address: Salisbury, Md Date signed 12/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

12826 33 1

Reg. Dist. No.

1. PLACE OF DEATH:
County Wicomico
City or town Delmar
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Delmar
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sadie Edith Bradley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Married

6.(b) Name of husband or wife Woodland Bradley
6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) May 6 1878

8. AGE: Years 67 | Months 7 | Days 6 | If less than one day ... hrs. ... min.

9. Birthplace Delmar, Wicomico, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Stacey Cutler
13. Birthplace Delmar Del.

MOTHER
14. Maiden name Mary Ellis
15. Birthplace Delmar Del.

16. Informant Woodland Bradley
Address Delmar Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/14/45 (month) (day) (year)
Cemetery or crematory Delmar Cemetery
Location Delmar Md.

18. Funeral director David L. Mezick
Address Delmar, Md.

19. Dec 13 19 45 Mrs JM Wallace
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/12/45 19... at 2:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1st 19 45 to December 12th 19 45 and that I last saw h[er] alive on December 12th 19 45

Immediate cause of death	DURATION
(a) Uremic Nephritis	
Due to	
Due to	
Other conditions Nephritis, Chronic interstitial. Duration: not known. Over	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE William Emrich M. D. or other
Address Delmar Md Date signed Dec. 13 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

12827

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Diat. No. 332

1. PLACE OF DEATH:
County: Wicomico
City or town: Near Willards, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Willards (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jessie Hilory Bratten

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Ida M. Bratten
6.(c) If alive, give age: dead years

7. Birth date of deceased (mo., day, yr.): Aug 3rd 1863

8. AGE:

Years	Months	Days	If less than one day
82	3	29	hrs. min.

9. Birthplace: Near Willards Md
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: William Bratten
13. Birthplace: Willards Md
MOTHER 14. Maiden name: Martha Jane Parker
15. Birthplace: Near Pittsville Md
16. Informant: Kate Bratten
Address: Willards Md
17. Burial, (Burial, cremation, or removal. Which?) Date thereof Dec 4 1945 (month) (day) (year)
Cemetery or crematory: Bratten Willards Md
Location: near Willards Md
18. Funeral director: Wm Howard Wells
Address: Pittsville Md
19. 12/3 1945 (Date rec'd by registrar) Lillian L. Davis Registrar
Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 2 1945, at 5:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1945 to Dec 2 1945 and that I last saw h... alive on Dec 2 1945

Immediate cause of death	DURATION
Coronary Occlusion	sudden
Due to: Generalized Arteriosclerosis	20 yrs
Due to: Hypertension	20 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. L. Purnell, M. D.
M. D. or other
Address: Berlin Md Date signed 12/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

12828

CERTIFICATE OF DEATH

Reg. Diat. No. 337

1. PLACE OF DEATH:
County Wicomico Co.
City or town Tyaskin, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Tyaskin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Jerry Brewington

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	col.	married

6.(b) Name of husband or wife Ella Brewington
6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Mar. 10 - 1888

8. AGE: Years	Months	Days	If less than one day
57	10	3	hrs. min.

9. Birthplace Allen, Md.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Geo. Brewington
13. Birthplace Allen, Md.

MOTHER
14. Maiden name Martha Pollitt
15. Birthplace Fruitlands, Md.

16. Informant Ella Brewington
Address Tyaskin, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/16/45 (month) (day) (year)
Cemetery or crematory Cemetery
Location Tyaskin Col. Church
18. Funeral director E. A. Messick
Address Bivalve, Md.

19. 12/15 (Date rec'd by registrar) 1945 R. Woolford Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 19 45, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 29 19 45, to Dec 13 19 45
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary Occlusion	6 da.
& Pneumonia.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE S. Allen Sullo. M. D. or other
Address Marumsco Md. Date signed 12-14-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12829

330

Reg. Diat. No. 64

1. PLACE OF DEATH:

County: Wicomico

City or town: Mardela Springs - Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months 8 days

Hospital, Institution, or street address where death occurred:
San Domingo

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Mardela Springs - Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. San Domingo
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME ~~Victoria V. Stanford~~ Diana Lillian Church

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age —

7. Birth date of deceased (mo., day, yr.) April 19, 1945

8. AGE: Years	Months	Days	If less than one day
—	8	8	...hrs. ...min.

9. Birthplace: Wicomico County, Maryland
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business —

FATHER
12. Name: Perry A. Church
13. Birthplace: Wicomico County, Maryland

MOTHER
14. Maiden name: Victoria V. Stanford
15. Birthplace: Wicomico County, Maryland

16. Informant: Victoria V. Stanford
Address: Mardela Springs, Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 31 1945 (month) (day) (year)

Cemetery or crematory: Quantico Colored Cemetery

Location: Quantico, Maryland

18. Funeral director: J. J. Frampton and Son

Address: Fedelaestung, Maryland

19. December 31 1945 (Date rec'd by registrar) J. J. Frampton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 27 1945, at 8:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Medical Examiners Report 19...
and that I last saw h... on 12/27 19...

Immediate cause of death	DURATION
Lobar Pneumonia	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) ...

Means of injury Injured at work?

23. SIGNATURE: Olive T. Tasker M.D.
Deputy Medical Examiner M. D. or other

Address: Fedelaestung Md. Date signed 12/28/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

12834

Reg. Dist. No. 233

1. PLACE OF DEATH

County: Wicomico

City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: P + B Hospital Salisbury

How long in hospital or institution? Near 4 days 1405

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Cola Thomas Cooper

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sallie Ann Cooper

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Nov 27 1908

8. AGE: Years	Months	Days	If less than one day
37	0	8	hrs. min.

9. Birthplace: Nr Willards Md (Town, county, and state)

10. Usual occupation: Farming + Trucking

11. Industry or business:

FATHER
12. Name: Wm L. Cooper
13. Birthplace: Near Willards Md

MOTHER
14. Maiden name: Iggie Littleton
15. Birthplace: Near Willards Md

16. Informant: Wm L Cooper
Address: R# Willards Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 8 - 1945 (month) (day) (year)

Cemetery or crematory: Cooper Cemetary

Location: Near Willards Md

18. Funeral director: Wm Howard Wells

Address: Pittsville Md

19. 12/8/45 (Date rec'd by registrar) 1945 Margaret E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/4/45, 19 45, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-2 19 45, to 12-4 19 45

and that I last saw h alive on 19

Immediate cause of death	DURATION
Bronchial Pneumonia, virus type	
Due to Duration, one week	1 wk
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. D. or other

Address: Date signed 12/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

12831

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death: 1 week

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Crisfield

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 209 Richardson Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: W. Hayward Daugherty

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lester Daugherty

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): September 25, 1887

8. AGE: Years	Months	Days	If less than one day
58	2	6	hrs. min.

9. Birthplace: Crisfield-Somerset-Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Retail lumber mill

FATHER 12. Name: Fleming Daugherty

FATHER 13. Birthplace: Crisfield, Maryland

MOTHER 14. Maiden name: Fanny Mills

MOTHER 15. Birthplace: Somerset County, Maryland

16. Informant: Mrs. Hayward Daugherty

Address: Richardson Ave., Crisfield, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 5, 1945 (month) (day) (year)

Cemetery or crematory: Crisfield Cemetery

Location: Crisfield, Maryland

18. Funeral director: H. Harvey Bradshaw

Address: Crisfield, Maryland

19. 12/6/45 (Date received by registrar) 19 Lassiter E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 1 1945 at 10:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 30 1945 to Dec 1 1945 and that I last saw him alive on Dec 1 1945

Immediate cause of death	DURATION
Acute cardiac failure	
Due to: Chronic myocarditis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Thos G. Lewis M. D. or other

Address: Salisbury, Md. Date signed: 12-8-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

12832

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I MARGIN RESERVED FOR BINDING

VS A15 7

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 Years

Hospital, Institution, or street address where death occurred:

John B. Parsons Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. John B. Parsons Home (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Emma P. Douglass

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FeMale	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May, 18, 1865

8. AGE: Years	Months	Days	If less than one day
80	6	26	hrs. min.

9. Birthplace Nanticoke, Wicomico, Co. Md (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Nehemiah Douglass

FATHER 13. Birthplace Wicomico, Co. Md

MOTHER 14. Maiden name Margarit White

MOTHER 15. Birthplace Wicomico, Co. Md

16. Informant John B. Parsons Home

Address Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 /16 /45 (month) (day) (year)

Cemetery or crematory Turner Cemetery

Location Naticoke, Md

16. Funeral director The Hill & Johnson Co.

Address Salisbury, Md

19. 12/16/45 Hazzie E. Johnson Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1945 at 530P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 28 1945 to Dec 14 1945 and that I last saw her alive on Dec 14th 1945

Immediate cause of death	DURATION
Embolus to heart.	
Due to Clot in Mitral Heart.	
Due to arteriosclerosis & Myocarditis,	
Other conditions Hypertension - followed by heart & Renal Disease	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Carrie L. Hearn M. D. or other

Address 203 N. Church St Date signed 12/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12833

Reg. Dist. No. 393

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 Weeks
Hospital, Institution, or street address where death occurred: U.S. Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Union Mill (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: John J. Ellis
3.(b) Social Security Number: None

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Cynthia J. Ellis
6.(c) If alive, give age: 78 years
7. Birth date of deceased (mo., day, yr.): Oct. 23 - 1875
8. AGE: Years: 70 Months: 1 Days: 10 If less than one day: hrs. min.
8. Birthplace: Berlin Worcester MD (town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: John L. Ellis
13. Birthplace: Maryland
MOTHER 14. Maiden name: Sallie Phillips
15. Birthplace: Maryland
16. Informant: Mr. Robert W. Ellis
Address: Union Mill, MD
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 5 '45 (month) (day) (year)
Cemetery or crematory: Whaleyville
Location: Union Mill, MD
18. Funeral director: Heame & Dennis
Address: Union Mill, MD
19. 12/6 1945 (Date rec'd by registrar) Margaret E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 3 1945 at 3:29 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1945 to Dec 3 1945 and that I last saw him alive on Dec 3 1945

	DURATION
Immediate cause of death: Ca of Prostate	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings of operations: Ca of Prostate
Date of op. 12/1/1945
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. W. Heb M. D. or other
Address: Salisbury Date signed: 12/4/1945

Dr. Wanner

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (937)

CERTIFICATE OF DEATH

12834

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town) Fruitland
How long in above place of death?
Hospital, institution, or street address where death occurred: U.S. Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 517 South Division St. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Georgia Anna Farlow

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: David Gibson Farlow
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): April 1- 1860
8. AGE: Years: 85 Months: 8 Days: 25 If less than one day: hrs. min.
9. Birthplace: R.D. Salisbury Md. (Town, county, and state)
10. Usual occupation: Home life
11. Industry or business: at Home
FATHER 12. Name: George Anderson
13. Birthplace: R.D. Salisbury Md.
MOTHER 14. Maiden name: Mary Ellen Anderson
15. Birthplace: R.D. Salisbury Md.
16. Informant: Mr. Clifford E. Farlow
Address: 517 S. Div. St. Salisbury Md
17. Buried (Burial, cremation, or removal. Which?) Date thereof Dec. 31-45 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland
18. Funeral director: Holloway & Miller R. Holloway
Address: Salisbury Maryland.
19. 12/31/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 26 1945 at 10 1/2 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 16 1945 to Dec 26 1945 and that I last saw h[illegible] alive on Dec 2[illegible] 1945

Immediate cause of death	DURATION
Acute myocarditis	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Wanner M.D. M. D. or other
Address: Salisbury Md. Date signed 12/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

12835

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(48-6)

CERTIFICATE OF DEATH

Reg. Diat. No. 933

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred:
Peninsular General Hospital

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Somerset

City or town East Princess Anne,
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lola C. Filkins

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife George M. Filkins 6.(c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1898

8. AGE: Years	Months	Days	If less than one day
47			....hrs. ....min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

FATHER 13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace Unknown

16. Informant Janet Williams Vanderhurst

Address R. F.D. #2 Boonton, N. J.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 31, 1945 (month) (day) (year)

Cemetery or crematory Friendship Cemetery

Location East Princess Anne Md.

19. Funeral director Dale Dashiell

Address Princess Anne Md.

19. 12/29/45 (Date rec'd by registrar) Maggie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/28/45 at 7.030 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1945 to 12/28 1945

and that I last saw h... alive on 12/28 1945

Immediate cause of death	DURATION
Carcinoma of Uterus	Yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. May 1945

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address [illegible] Date signed 12/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75-1)

12836

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1
Hospital, institution, or street address where death occurred: P.G. Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. #1
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Susan Carol Gallahan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 9 1945

8. AGE: Years | Months | Days: 2 | If less than one day: hrs. min.

9. Birthplace: P.G. Hospt. Salisbury Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: James A. Gallahan
FATHER — 13. Birthplace: Fredericksburg Virginia

MOTHER — 14. Maiden name: Mary Louise Bentsen
MOTHER — 15. Birthplace: Chad Point Maryland

16. Informant: Mr. James A. Gallahan
Address: R.D. #1. Salisbury Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Dec. 13-45 (month) (day) (year)
Cemetery or crematory: Chad Point Church Cem
Location: Chad Point Maryland

18. Funeral director: Leona & C. Walter P. Hollman
Address: Salisbury Maryland.

19. 12/13 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 11th 19 45 at 3:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 Dec. 1945 to 11 Dec. 1945 and that I last saw h. alive on 11 Dec. 1945

Immediate cause of death	DURATION
Hemolytic anemia of the newborn	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. W. Keen M. D. or other
Address: Salisbury, Md. Date signed: 12/13/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-d)

CERTIFICATE OF DEATH

12837

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Solomt 60 years
Hospital, Institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 128 E. Pine
(If rural, give LOCATION) no
2.(a) If veteran, name war: no

3. (a) FULL NAME: Mary E Gunby

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	C.A.	Married

6.(b) Name of husband or wife: John W. Gunby
B.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): about 1871

8. AGE: Years	Months	Days	If less than one day
about 74			....hrs. ....min.

9. Birthplace: Eden Md (Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business: Same as above

FATHER
12. Name: Art Barkley
13. Birthplace: Eden md

MOTHER
14. Maiden name: Angeline Graham
15. Birthplace: Fruitland md

16. Informant: Mrs Sallie Hearn
Address: Salisbury Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Dec. 6 - 1945 (month) (day) (year)
Cemetery or crematory: Hanston
Location: Salisbury Md

18. Funeral director: Jesse A. Stewart
Address: Salisbury Md

19. 12/6/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-3 1945, at 2-10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-1 1945, to 11-2 1945
and that I last saw h...e alive on 11-2 1945

Immediate cause of death	DURATION
Pulmonary congestion	
Due to: Left Ventricular Failure	3 yrs.
Due to: Arteriosclerosis	Undet.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ....Date of ....
Where did injury occur? ....(City or town) ....(County) ....(State)
Injured at home, farm, industry, public place (where?) ....
Means of injury: ....Injured at work?

23. SIGNATURE: E. A. Purnell M.D.
M. D. or other
Address: 600 E. Main St. Date signed 12-4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12838 336

Reg. Dist. No. 11

1. PLACE OF DEATH:

County: Wicomico

City or town: Delmar
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Delmar
(If outside city or town limits, write RURAL and give nearest town)

Street No. 408 State St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Sarah Hester Virginia Guthrie

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Wm. H. Guthrie

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 9- 1865

8. AGE: Years: 80 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Sussex County, Del.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER
12. Name: Joseph C. Ellis
13. Birthplace: Delmar, Del RFD

MOTHER
14. Maiden name: Rebecca A. Knowles
15. Birthplace: Sussex County, Del

18. Informant: W. C. Guthrie

Address: Delmar Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-21-45 (month) (day) (year)

Cemetery ~~or crematory~~: Mt. Olive Guthrie

Location: Delmar Del.

18. Funeral director: W. D. Tyndall Co

Address: Delmar Del

19. 12-21- 1945 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 18 1945, at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945 to Dec 18 1945

and that I last saw h.er alive on Dec 18 1945

	DURATION
Immediate cause of death: Acute Cardiac Dilatation	1 month
Due to: Fibrosis of myocardium, Arteriosclerosis, and Senility	2 months
Due to: Cystitis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. H. Tyndall M. D. or other

Address: Delmar Del. Date signed Dec 20/45

VS A15 9.45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlen St., Baltimore (31a)

CERTIFICATE OF DEATH

12839

Reg. Dist. No. 233

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 Years

Hospital, Institution, or street address where death occurred:

105 Fooks St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 105 Fooks (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Laura Elizabeth Harvey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April, 8 1854

8. AGE: Years	Months	Days	If less than one day
91	8	21	hrs. min.

9. Birthplace: Dorchester, Co. Md (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

12. FATHER — Name: Williams Harvey

13. Birthplace: Dorchester, Co. Md

14. MOTHER — Maiden name: Katherine Dayton

15. Birthplace: Dorchester, Co. Md

16. Informant: Mrs. E.E. Twilley

Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/31/45 (Month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury, Md

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Md

19. 12/31 19 45 Hill & Johnson Co. Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 29, 1945, 10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 19 44, to Dec 29 19 45

and that I last saw h.e.r alive on Dec 27th 19 45

Immediate cause of death	DURATION
Cardiac vascular renal	
Due to: Anuria	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Hill & Johnson Co. M. D. or other

Address: Salisbury Md Date signed 12-31-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-a

CERTIFICATE OF DEATH

12841

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Near Willards
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Avory Nathanal Hearn

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 9 1908

8. AGE: Years 37 | Months 7 | Days 7 | If less than one day: hrs. min.

9. Birthplace: Near Willards Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Austin Hearn
13. Birthplace: Near Willards Md

MOTHER
14. Maiden name: Martha Fecurts
15. Birthplace: Near Willards Md

16. Informant: Austin Hearn
Address: Willards Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 18-1945 (month) (day) (year)
Cemetery or crematory: Willards Cemetary
Location:

18. Funeral director: Wm Howard Welle
Address: Pittsville Md

19. 12/18/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 16th 19 45, at 2-30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 5, 1945 to Dec 16, 1945 19
and that I last saw him alive on Dec 5, 1945 19

Immediate cause of death	DURATION
Pneumonia, influenza	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results: Mr autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Frank P Lewis M D
M. D. or other
Address: Pittsville Md Date signed: 12-17-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

12841

Reg. Dist. No. 903

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Wicomico
County
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, institution, or street address where death occurred: 415 Davis Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 415 Davis St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Emma Hill

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Henry W. Hill
6.(c) If alive, give age: 75 years
7. Birth date of deceased (mo., day, yr.): May 12-1862
8. AGE: Years: 83 Months: 6 Days: 21 If less than one day: hrs. min.
9. Birthplace: R.D. Princess Md. (Town, county, and state)
10. Usual occupation: Home keeper
11. Industry or business:
FATHER 12. Name: Deleta
FATHER 13. Birthplace: Somerset Co. Md.
MOTHER 14. Maiden name: No Record
MOTHER 15. Birthplace:
16. Informant: Mrs. Samuel Williams
Address: 102 Holland ave. Salisbury Md
17. Buried (Burial, cremation, or removal. Which?) Date thereof Dec. 6-45 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland
18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Maryland.
19. 12/6/45 (Date rec'd by registrar) Mabel E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 3rd 1945 at 930 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1945, to Dec 3 1945
and that I last saw h.. alive on Dec 3, 1945 1945
Immediate cause of death: Cardiac vascular renal disease — DURATION
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN—Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?
23. SIGNATURE: Harry A. Lee M. D. or other
Address: Salisbury Md. Date signed 12-4-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(159)

12842

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution or street address where death occurred:
P.B. Hoyt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 556 S. Division st.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Baby Hinchcliff

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 21 - 1945

8. AGE: Years	Months	Days	If less than one day
0	0	0	1 hrs. 15 min.

9. Birthplace P.B. Hoyt. Salisbury Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Stanley Clyde Hinchcliff
13. Birthplace Salisbury Maryland

MOTHER
14. Maiden name Mary Louise Hopkins
15. Birthplace Salisbury Maryland

16. Informant Mr. Stanley C. Hinchcliff
Address 556 S. Div st. Salisbury Md

17. Burial Date thereof Dec. 21 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Parsons Cem.
Location Salisbury Maryland

18. Funeral director Holloway & Co. Walter R. Holloway
Address Salisbury Maryland

19. 12/21/1945 Received by Registrar
(Date recd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21st 1945 at 3 o'clock P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Due to Prematurity	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Geo. A. Dudley M. D. or other
Address Salisbury Md. Date signed 12-21-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

12843 330

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Mardela Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Dorchest
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Rebecca C. Holder
3.(b) Social Security Number:

4. Sex: F
5. Color or race: White
6.(a) ~~Single, married, widowed, or divorced~~:
6.(b) Name of husband or wife: Thomas J. Holder
6.(c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): 1860

8. AGE: Years: 85 Months: Days: If less than one day: hrs. min.

9. Birthplace: Dorchester Md
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business:
FATHER 12. Name: Dale Howeth
13. Birthplace: Md
MOTHER 14. Maiden name: Mary Lord
15. Birthplace: Md
16. Informant: Lelia Newhard
Address: Seaford, Del R.D.
17. (Burial, cremation, or removal. Which?) Date thereof: 12-16 1945 (month) (day) (year)
Cemetery or crematory: McKendree
Location: Near Rhodesdale Md
18. Funeral director: Graveson Bros
Address: Sharptown
19. 12/16/45 19— (Date rec'd by registrar) W. H. Shores Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 13 1945 et. 85 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 10 1945 to Dec 13 1945 and that I last saw h— alive on Dec 13 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. S. Kellum
M. D. or other
Address: Sharptown Md Date signed: 12/16/45

Evidence for change of year of birth of deceased is shown on FILM No. I 01 APR 11 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4a)

CERTIFICATE OF DEATH

12844

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution Peninsula General Hospital

Stay in hospital or inst. (yrs., or mos., or days) 9 hours

Stay in this community (yrs., or mos., or days) 9 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Delaware County Sussex

City or town Laurel Del. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. West 6 St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Pauline Horsey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F, M.	Col.	Single

6 (b) Name of husband or wife —

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 13th 1929 1-939

8. AGE:

Years	Months	Days	If less than one day
16	7	10	____ hrs. ____ min.

9. Birthplace Laurel Sussex County
(Town, county, and state)

10. Usual occupation Home Work.

11. Industry or business

FATHER
12. Name Howard Horsey
13. Birthplace Delaware

MOTHER
14. Maiden name Jearline Dashiell
15. Birthplace Delaware

16. Informant Howard Horsey.
Address Laurel Del.

17. Burial Date thereof 12-27-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Jean Cemetary
Location Laurel Del

18. Funeral director Riggin & Cooper
Address Laurel Del.

19. 12/27/1945 Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-23 1945, at 6:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-2/1945, to 12-23 1945, and that I last saw her alive on 12-22 1945.

Immediate cause of death Placenta Previa — DURATION

Due to —

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE C. M. Mowbray, M. D. or other

Address Laurel Date signed 12/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12845

Reg. Diat. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Year
Hospital, Institution, or street address where death occurred:
304 Royal St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 304 Royal St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James P. Humphreys

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife Lillian Humphreys
6.(c) If alive, give age 1-6 years

7. Birth date of deceased (mo., day, yr.) July 18, 1876

8. AGE: Years	Months	Days	If less than one day
69	5	10	...hrs. ...min.

9. Birthplace Rockawalkin, Wicomico Co. Md
(Town, county, and state)
10. Usual occupation Salesman
11. Industry or business
FATHER 12. Name William Humphreys
13. Birthplace Wicomico Co. Md
MOTHER 14. Maiden name Elizabeth Weatherly
15. Birthplace Wicomico Co. Md
16. Informant Mr Jame Humphreys
Address Baltimore, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/31/45 (month) (day) (year)
Cemetery or crematory Rockawalkin Cemetery
Location Rockawalkin Md
18. Funeral director The Hill & Johnson Co. Md
Address Salisbury Md
19. 12/31/45 Gabriel E. Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28, 1945 at 3:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 26 to Dec 28, 19...
and that I last saw h... alive on ..., 19...

Immediate cause of death	DURATION
Coronary Thrombosis	sudden
Due to Chronic Myocarditis	several months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas T. Finder M.D.
M. D. or other
Address Salisbury Md Date signed 12-29-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for addition of approximate age of deceased is shown on
FILM No. 100 JAN 18 1946

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

12846

VS. A15 — MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) County Wicomico
(b) City or town Rockawalkin (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Nil
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Jones, Dale

3 (b) If veteran, name war
3 (c) Social Security No.

4. Sex Male
5. Color or race Col.
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)
8. AGE: Years Months Days If less than one day ___hr. ___min.
Approx. 52 unknown
9. Birthplace (Town, county, and state)
10. Usual occupation unknown
11. Industry or business
FATHER 12. Name unknown
13. Birthplace
MOTHER 14. Maiden Name unknown
15. Birthplace
16 (a) Informant
(b) Address
17 (a) (Burial, cremation, or removal) (b) Date thereof Dec 24 1945 (month) (day) (year)
(c) Cemetery or crematory
Location
18 (a) Funeral director J. Harvey Williamson
(b) Address Salisbury, Md.
19 (a) 12/30/1945 (b) Harriet E. Johnson Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. Date of death Dec 22 1945, at unknown M
21. I certify that death occurred on the date above stated; that I attended deceased from Dead 19___, to 19___, and that I last saw him alive on Dead 19___.

Immediate cause of death	Duration
Generalized Burns	Sudden death
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations None
Of autopsy None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12/22/45
(c) Where did injury occur? Rockawalkin Wicomico Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Shanty caught fire

23. **Signature** J. A. Roderick ... Deputy Med Ex. M. D. or other
Address Salisbury, Md Date signed 12/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12847

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 minutes

Hospital, Institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution? 15 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. 113 3rd St
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME (Langston) Langston Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Mrs Willie James

6.(c) If alive, give age: Yes years

7. Birth date of deceased (mo., day, yr.): Dec 26, 1903

8. AGE: Years	Months	Days	If less than one day
42	11	13	hrs. min.

9. Birthplace: Philadelphia Pa
(Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: Same as above

FATHER 12. Name: Joseph Waters

FATHER 13. Birthplace: Somerset Co

MOTHER 14. Maiden name: Mamie Jones

MOTHER 15. Birthplace: Somerset Co

16. Informant: Mrs Willie James

Address: Salisbury Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof Dec. 12 1945 (month) (day) (year)

Cemetery or crematory: Princess Anne

Location: Princess Anne, Md

18. Funeral director: James F. Stewart

Address: Salisbury Md

19. 12/13/45 (Date rec'd by registrar) 19 H. C. Bassett Jr. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 9 1945, at 6 50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... to ... 19..; and that I last saw h... alive on ... 19..

Immediate cause of death	DURATION
(a) Crushed chest Left	1/2 hr
(b) Fractured Left arm	
Due to (c) Lacerated scalp	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 12/9/45

Where did injury occur? Fruitland (City or town) Wicomico (County) Md (State)

Injured at home, farm, Industry, public place (where?) Highway

Means of injury: struck by Truck Injured at work? / No

23. SIGNATURE: H. A. Rademaker MD Deputy Med Examiner
M. D. or other

Address: Salisbury Md Date signed 12/9/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

12848

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (106c)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: P.R. Hosp.
How long in hospital or institution? dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Worcester
City or town Bishopville (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Harry Charles McCabe
3. (b) Social Security Number

4. Sex: Male
5. Color or race: white
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) July 24. 1945
8. AGE: Years — Months 4 — Days — If less than one day 26 hrs. ... min.
9. Birthplace Bishops Md. Worcester (Town, county, and state)
10. Usual occupation None
11. Industry or business —
FATHER 12. Name Charles L. McCabe
13. Birthplace Bishops Md.
MOTHER 14. Maiden name Mildred A Parsons
15. Birthplace Pittsville Md.
16. Informant Charles L. McCabe
Address Bishops Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 23. 45 (month) (day) (year)
Cemetery or crematory Line Cem Whitesville Del.
Location Whitesville Del.
18. Funeral director Holloway & Co. Walter R. Holloway
Address Salisbury Md.
19. 12/22/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 20 19 45, at 8 30 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... and that I last saw h... alive on ... 19 ... medical examiner's case
Immediate cause of death: acute tracheobronchitis — DURATION 24 hrs
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?
23. SIGNATURE J.A. Kademaker M.D. Deputy Med Examiner — M.D. or other
Address Salisbury Md — Date signed 12/20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

12849

Reg. Diat. No. 999

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Delaware County: Sussex

City or town: Delmar
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Post 2 M. St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Nelson Mrs. Lennie

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	

6.(b) Name of husband or wife: Mrs Williams S. Nelson

B.(c) If alive, give age: 83 years

7. Birth date of deceased (mo., day, yr.): Oct 8-1866

8. AGE: Years: 79 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Worcester County Md
(Town, county, and state)

10. Usual occupation: House W'f

11. Industry or business: Home

FATHER
12. Name: James Lewis
13. Birthplace: Worcester County Md

MOTHER
14. Maiden name: Martha Camp
15. Birthplace: Worcester County, Md

16. Informant: Mrs S. Nelson

Address: Delmar Del

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 12-16-45 (month) (day) (year)

Cemetery ~~or crematory~~: Bi E

Location: Delmar Del.

18. Funeral director: W. S. Marvel Co.

Address: Delmar, Delaware

19. 12/16/1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 13 1945 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 6 1945, to Dec 13 1945

and that I last saw her alive on Dec 13 1945

Immediate cause of death	DURATION
Carcinoma of Colon	Mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 8 months of death)

Major findings of operations: C. of Colon.

Date of op. 12/11/45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Date signed 12/14/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(H) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

12850

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution or street address where death occurred: 415 Dans St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits write RURAL and give nearest town)
Street No. 415 Dans St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Willie Elizabeth Mills

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 5th 1859 (3/5/59)

8. AGE: Years: 86 yrs. Months: 9 Days: 20 If less than one day: hrs. min.

9. Birthplace: R.D. Eden Maryland (Town, county, and state)

10. Usual occupation:
11. Industry or business: at Home

FATHER
12. Name: William Mills
13. Birthplace: Somerset Co. Md.

MOTHER
14. Maiden name: Mary Ann Dennis
15. Birthplace: Somerset Co. Md.

16. Informant: Mrs Ringgold Jackson
Address: 233 S. Division St. Salisbury Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Dec 28-45 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md.

18. Funeral director: Holloway & Drafton R. Holloway
Address: Salisbury Md.

19. (Date rec'd by registrar) 12/28/45 Registrar: Margaret E. Dougherty

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25 1945, at 9 00 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 19 to December 25 1945
and that I last saw h alive on 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 hour
Due to: Senility	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Elmer T. Tucker M. D. or other
Address: Salisbury Md. Date signed: 12/28/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Yeaman

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

12851

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs 7 mos
Hospital, Institution, or street address where death occurred: R.D. #2
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. #2
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Theodore Parsons Nicholson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary C. Nicholson
6.(c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): March 22 - 1861

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
84	8	9		

9. Birthplace: R.D. #2 Salisbury Md.
(Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business:

FATHER
12. Name: Levin Nicholson
13. Birthplace: R.D. #2. Salisbury Md.

MOTHER
14. Maiden name: Elizabeth Jenkins
15. Birthplace: R.D. # Salisbury Md.

16. Informant: Mrs. Mary C. Nicholson
Address: R.D. #2. Salisbury Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 3 1945 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury Maryland
18. Funeral Director: Holloway & Co. Walter P. Holloway
Address: Salisbury Maryland

19. 12/3 19 ## Received by Harold E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 1st 19 45 at 2 15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 24, 1945, to Dec 1 1945
and that I last saw h.. alive on Dec 1, 1945 19
Immediate cause of death: Gangrene, both lower extremities — DURATION: 5 days
Due to: Arteriosclerosis — DURATION: ?
Due to: — DURATION:
Other conditions: — DURATION:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John H. Yeaman M. D. or other
Address: 230 Camden Ave. Salisbury Date signed: Dec 3, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

12852

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (115-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: P.H. Hospl.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Somerset
City or town: Princess Anne
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. # 2
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Joseph Edward Owens

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mildred R. Owens
6.(c) If alive, give age: 23 years

7. Birth date of deceased (mo., day, yr.): June 30 - 1917

8. AGE: Years	Months	Days	If less than one day
28	5	10	...hrs. ...min.

9. Birthplace: Kaiser W. Va. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
12. FATHER — Name: Peter Simpson
13. FATHER — Birthplace: Kaiser W. Va.
14. MOTHER — Maiden name: Lucy Huffman
15. MOTHER — Birthplace: Rand W. Va.
16. Informant: Mrs. Mildred R. Owens
Address: R.D. #2 Princess Anne Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 12-1945 (month) (day) (year)
Cemetery or crematory: Allen Church Cem.
Location: Allen Maryland
18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Maryland
19. 12/12/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 10th 1945 at 12.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19... and that I last saw h... alive on ...19...

	DURATION
Immediate cause of death: ascending degeneration of optical cord	24 hr.
Due to: fracture of cervical spine	36 hr.
Due to:	
Other conditions: Unlocated left shoulder	72

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: Dec 8, 1945
Where did injury occur? Princess Anne (City or town) Somerset (County) Md (State)
Injured at home, farm, industry, public place (where?): Farm
Means of injury: Tractor accident Injured at work? yes

23. SIGNATURE: Joe Rodemeyer M.D. Deputy Med Examiner M. D. or other
Address: Salisbury Md Date signed: 12/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

12853

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico

County ..... Wicomico

City or town ..... Parsonsburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred: RD. #2

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Parsonsburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. RD. #2

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Patricia Lee Parsons

3.(b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 6-1945

8. AGE: Years ..... Months ..... Days 2 If less than one day ..... hrs. ..... min.

9. Birthplace RD. #2. Parsonsburg Md

(Town, county, and state)

10. Usual occupation None

11. Industry or business .....

MOTHER FATHER

12. Name Willie Edward Parsons

13. Birthplace Pittsville Md.

MOTHER

14. Maiden name Mabel Virginia Brown

15. Birthplace Accomac Co. Virginia

16. Informant Mrs. Willie E. Parsons

Address RD. #2. Parsonsburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 10-1945 (month) (day) (year)

Cemetery or crematory Charity Church Cem.

Location RD. #2 Salisbury Md.

18. Funeral director Holloway & Waller

Address RD. #2. Salisbury Md.

19. 12/10 19 45 Harriet A. Johnson Local Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8th 1945 at 4 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 6 1945 to Dec 8 1945

and that I last saw him alive on Dec 7 1945

Immediate cause of death: Acute hemorrhage from stomach & bowel — DURATION: 2 hours

Due to: Cause not ascertained

Due to: .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H. A. Lord M. D. or other

Address Salisbury Md. Date signed 12/10/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 44

CERTIFICATE OF DEATH

12854

Reg. Diat. No. 293

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Rural — Salisbury, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Saunders Peters

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 29, 1944

8. AGE:	Years	Months	Days	If less than one day
	1	3	16	..... hrs. ..... min.

9. Birthplace: Salisbury, Wicomico, Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Samuel D. Peters

FATHER 13. Birthplace: Salisbury

MOTHER 14. Maiden name: Christine Long

MOTHER 15. Birthplace: Tyaskin, Md.

16. Informant: Olivia Long

Address: Tyaskin, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/20/45 (month) (day) (year)

Cemetery or crematory: Cemetery (New Town)

Location: near New Town Church

18. Funeral director: E. E. Messick

Address: Bivalve, Md.

19. 12/20/1945 (Date rec'd by registrar) Maggie E. Dashiell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 18th 19 45, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 ..... and that I last saw h..... alive on ..... 19 .....

Medical Examiner Reports

	DURATION
Immediate cause of death: Bronchopneumonia	2 days
Due to: measles	3 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Adam T. Trieber M.D.

M. D. or other

Address: Salisbury Md Date signed: 12/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

12855

Reg. Dist. No. 333

1

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury District (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Day

Hospital, Institution, or street address where death occurred:

Pusey Farm

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Wicomico

City or town 214 Newton St. (If outside city or town limits, write RURAL and give nearest town)

Street No. Salisbury, Md (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elihu J. Pusey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary R. Pusey

6.(c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) July 6, 1858

8. AGE: Years	Months	Days	If less than one day
87	4	28	...hrs. ...min.

9. Birthplace Rockawalkin, Wicomico, Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Elijah Pusey

FATHER 13. Birthplace Wicomico Co. Md

MOTHER 14. Maiden name Margaret Sheppard

MOTHER 15. Birthplace Wicomico Co. Md

16. Informant Mrs. L. Paige Pennewell

Address Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/7/45 (month) (day) (year)

Cemetery or crematory Parsons Cemery

Location Salisbury, Md

19. Funeral director The Hill & Johnson Co.

Address Salisbury, Md

19. 12/7/45 (Date rec'd by registrar) Harriet S. Johnson (Seal) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4 1945 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ...19... to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

...Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide... Date of...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE L.A. Carbaugh M.D. Deputy Med. Examiner M. D. or other

Address Salisbury, Md Date signed 12/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12856

Reg. Dist. No. 393

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 11 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. Eleven Acres
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lyle, Mrs. Marion

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Lallie A. Pyle
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 26 1867

8. AGE: Years 93 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual occupation Retired
11. Industry or business "

FATHER 12. Name Henry L. Coates
13. Birthplace Md.

MOTHER 14. Maiden name Elizabeth Haggerty
15. Birthplace Md.

16. Informant Mrs. James R. Bishop
Address Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 31, 1945 (month) (day) (year)
Cemetery or crematory London Park Cemetery
Location Baltimore, Md.

18. Funeral director M. Parks Watson
Address Selbyville, Del.

19. 12/28/1945 (Date rec'd by registrar) Harriet L. Dashiell (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1945 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 17 1945 to Dec 28 1945
and that I last saw her alive on Dec 27, 1945

	DURATION
Immediate cause of death Cerebral Thrombosis	48 hrs
Due to Arteriosclerosis	20 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op.
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm. R. Bishop M. D.
M. D. or other
Address Salisbury, Md. Date signed Dec 28 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12857

Reg. Diat. No. 999

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred: Peninsula General Hospital.

How long in hospital or institution? 1 day.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Berlin (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mildred Nelson Payne

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 16, 1900

8. AGE: Years 45 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Bishopsville (Town, county, and state)

10. Usual occupation: Nurse

11. Industry or business:

FATHER — 12. Name: Timothy N. Payne

13. Birthplace: Md.

MOTHER — 14. Maiden name: Laurie E. Collins

15. Birthplace: Md.

16. Informant: Paul Payne

Address: Bishopsville Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Dec 10, 1945 (month) (day) (year)

Cemetery or crematory: O.L.F.

Location: Bishopsville, Md.

18. Funeral director: McPasha Watson

Address: Selbyville, Del.

19. (Date rec'd by registrar) 12/10, 1945 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/9 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/8 1945 to 12/9 1945 and that I last saw h[illegible] alive on 12/9 1945

Immediate cause of death	DURATION
Rheumatic heart disease	
Due to: Myocarditis Fatty	Few
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: [illegible] Date signed 12/10/45

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12858

Reg. Diat. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 54 Years

Hospital, institution, or street address where death occurred:
102 Walnut St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. 102 Walnut St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Arthur P. Richardson Sr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Alivia T. Richardson

6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1881

8. AGE: Years	Months	Days	If less than one day
64	0	23	...hrs. ...min.

9. Birthplace Worcester, Co. Md
(Town, county, and state)

10. Usual occupation Salesman

11. Industry or business Plumbing & Heating

FATHER
12. Name John E. Richardson
13. Birthplace Worcester, Co. Md

MOTHER
14. Maiden name Amelia Anne Baker
15. Birthplace Worcester, Co. Md

16. Informant Mrs Arthur P. Richardson Sr.
Address Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 / 12 / 45 (month) (day) (year)

Cemetery or crematory Parsons Cemetery

Location Salisbury, Md

18. Funeral director The Hill & Johnson Co.

Address Salisbury, Md

19. 12/12/45 (Date rec'd by registrar) Thomas E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10, 1945 at 2.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... one Sept 15 1945

and that I last saw him alive on Dec 10th 1945

Immediate cause of death	DURATION
Embolus & Heart.	
Due to Myocarditis	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE C. J. Henry M. D. or other

Address 203 N. Church St. Date signed 12/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

12859

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83d

CERTIFICATE OF DEATH

Reg. Dist. No. 335

1. PLACE OF DEATH:

County Wicomico County

City or town Mardela Springs - Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
San Domingo

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Mardela Springs - Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. San Domingo
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Hattie M. Roberts

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife Levin Roberts

B.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 17, 1887

8. AGE: Years 58 | Months 8 | Days 18 | If less than one day ... hrs. ... min.

9. Birthplace Wicomico County, Maryland
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER 12. Name Leonard Gaines

FATHER 13. Birthplace Wicomico County, Maryland

MOTHER 14. Maiden name Martha Jane Brown

MOTHER 15. Birthplace Wicomico County, Maryland

16. Informant Mrs. Martha Cline

Address 1812 West 3rd St., Wilmington, Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof December 10 1945 (month) (day) (year)

Cemetery or crematory San Domingo Cemetery

Location Near Shanetown, Maryland

18. Funeral director J. T. Frampton and Son

Address Fredericksburg, Maryland

19. Dec. 10 1945 (Date rec'd by registrar) Walter J. Mann Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5 1945 at 5:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 2 1940 to Dec. 5 1940 and that I last saw him alive on Dec. 5 1940

Immediate cause of death Paraplegia — DURATION 4 mo.

Due to Hypertension — DURATION 2 years

Due to — DURATION —

Other conditions — DURATION —

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE Edmund T. Orth M. D. or other

Address Easton, Md. Date signed 12/7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

12864

Reg. Diat. No. 2333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury, R.D. 1
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Siloam
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ruth Blanche Smith

3.(b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Edward J. Smith ✓

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): May 30, 1896.

8. AGE:

Years	Months	Days	If less than one day
55	6	12	...hrs. ...min.

9. Birthplace: Wicomico Co., Md.
(Town, county, and state)

10. Usual occupation: At Home ✓

11. Industry or business:

FATHER
12. Name: George Matthews
13. Birthplace: Wicomico Co., Md.

MOTHER
14. Maiden name: Virginia Mills
15. Birthplace: Wicomico Co., Md.

16. Informant: Edward J. Smith
Address: Salisbury, Md. R.D. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/16/45. (month) (day) (year)

Cemetery or crematory: Siloam

Location: Siloam, Md.

18. Funeral director: The Wills & Wilson Co.

Address: Salisbury, Md.

19. 12/16, 1945. Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 12, 1945, at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 8, 1945, to Dec 12, 1945, and that I last saw h[illegible] alive on Dec 11, 1945.

Immediate cause of death	DURATION
Uremia	
Due to: Left renal artery thrombosis	
Due to: Pregnancy	
Other conditions: Pregnancy Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results: See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ...

Means of injury: ...Injured at work?

23. SIGNATURE: Wm. D. Gray M.D.
M. D. or other

Address: Salisbury, Md. Date signed: 12/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Rademaker

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (60-3)

CERTIFICATE OF DEATH

Reg. Dist. No. 12333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Del. County: Sussex

City or town: Seaford

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.R. # 3

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Stevens

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	

6.(b) Name of husband or wife:

6.(c) If alive, give age: yeare

7. Birth date of deceased (mo., day, yr.): Dec. 12, 1945

8. AGE: Years | Months | Days: 3 | If less than one day: hrs. min.

9. Birthplace: P.G. Hospital Salisbury Md (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: John Stevens

13. Birthplace: Md

MOTHER — 14. Maiden name: Alice Kimmy

15. Birthplace: Md

16. Informant: John Stevens

Address: Seaford Del R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12 15 1945 (month) (day) (year)

Cemetery or crematory: Galestown Md

Location:

18. Funeral director: Graves & Bros

Address: Sharptown Md

19. (Date rec'd by registrar) 12/15/1945 Margaret E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 15 1945 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 12 1945 to Dec 15 1945 and that I last saw her alive on Dec 14 1945

Immediate cause of death	DURATION
Pulmonary Atelectasis	3 days
Due to: Premature delivery	7½ mos
Due to: Premature separation of placenta in mother	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.:

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J.A. Rademaker M.D.

M. D. or other

Address: Salisbury Md Date signed: 12/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

12862

Reg. Dist. No. 41336

1. PLACE OF DEATH:

County: Wicomico

City or town: Delmar

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Delmar

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ora Belle Adams Todd

3.(b) Social Security Number: C

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F. M.	White	Widow

6.(b) Name of husband or wife: Joseph Todd C

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 2-6-1874

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
71	6	24		

9. Birthplace: Sussex County (Town, county, and state)

10. Usual occupation: Farm work

11. Industry or business:

FATHER — 12. Name: Josiah W Thompson

FATHER — 13. Birthplace: Del

MOTHER — 14. Maiden name: Julia Cooper

MOTHER — 15. Birthplace: Del Sussex County

16. Informant: J Thomas Adams

Address: Laurel Del

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-2-46 (month) (day) (year)

Cemetery or crematory: Portsville

Location: Portsville

18. Funeral director: Riggin & Cooper

Address: Laurel Del

19. June 2 1946 (Date rec'd by registrar) Harry E Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-30 1945 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1 1945 to Dec 30 1945

and that I last saw her alive on Dec. 30 1945

	DURATION
Immediate cause of death: Myocardial failure	2 days
Due to: Upper respiratory infection	2 weeks
Due to:	
Other conditions: Diabetes mellitus	several years
Pyelitis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. V. Fowler M.D.

M. D. or other

Address: Delmar Del Date signed 12-31-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

12863

Reg. Dist. No. 3333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 Years

Hospital, Institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution? 1 Week

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 119 Elizabeth (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Caroline Crosby Waller

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife G.W.D. Waller

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1872

8. AGE: Years	Months	Days	If less than one day
73	0	19	..... hrs. ..... min.

9. Birthplace Vienna, Dorchester Co. Md (Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER 12. Name George Crosby

13. Birthplace Dorchester, Co. Md

MOTHER 14. Maiden name Julia Lake Newton

15. Birthplace Dorchester, Co. Md

16. Informant Mrs Robert Waller

Address Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 / 10 / 45 (month) (day) (year)

Cemetery or crematory Parsons Cemetery

Location Salisbury, Md

18. Funeral director The Hill & Johnson Co.,

Address Salisbury, Md

19. 12/10, 1945 Harriet E. Johnson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7, 1945 5354 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 2 1945 to Dec 7 1945

and that I last saw h.. alive on Dec 6 1945

Immediate cause of death	DURATION
Pneumonia	5 Days
Due to	
Due to	
Other conditions Chronic myocarditis	3
Chronic phlebitis	2

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. Brenner M. D.

M. D. or other

Address Salisbury Md Date signed 12/8/45

M MARGIN RESERVED FOR BINDING

I PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73d)

CERTIFICATE OF DEATH

12864

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 24 years

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury Md (If outside city or town limits, write RURAL and give nearest town)

Street No. 518 W. Isabella (If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Edith Anna Polk Waller

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a.a.	married

6.(b) Name of husband or wife: Lewis Waller Don't know

6.(c) If alive, give age: yes years

7. Birth date of deceased (mo., day, yr.): 8-8-[illegible]

8. AGE: Years: about 63 Months: 8 Days: If less than one day ... hrs. ... min.

9. Birthplace: Mardella Springs Md (Town, county and state)

10. Usual occupation: Housewife

11. Industry or business: Same as above

FATHER — 12. Name: Elias Polk

FATHER — 13. Birthplace: Laurel Del

MOTHER — 14. Maiden name: Leah E Hall

MOTHER — 15. Birthplace: Westfield Wicomico Co Md

16. Informant: Lewis Waller

Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 27 1945 (month) (day) (year)

Cemetery or crematory: Mardella

Location: Mardella Springs Md

18. Funeral director: James H. Stewart

Address: Salisbury Md

19. (Date rec'd by registrar) 12/27/1945 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 24 1945, at 11 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 13, 1945, to Dec 24 1945

and that I last saw her alive on Dec. 24, 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	5 mos.
Due to: Hypertension	5 years
Other conditions: Myocarditis	5 years

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: G Herbert Tembly MD M. D. or coroner

Address: 500 E Church St Salisbury Md Date signed 12-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12865

Reg. Dist. No. T1336

1. PLACE OF DEATH

County: Wicomico

City or town: Delmar

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 108 W. State St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Delmar (If outside city or town limits, write RURAL and give nearest town)

Street No.: 108 W. State St (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ernest William West

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Maggie West

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): May 8 1880

8. AGE: Years: 65 Months: Days: If less than one day: hrs. min.

8. Birthplace: Delmar, Md. (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business: Farm

FATHER — 12. Name: Jack West

FATHER — 13. Birthplace: Delmar, Md.

MOTHER — 14. Maiden name: Mary Stevens

MOTHER — 15. Birthplace: Delmar, Md.

16. Informant: Mrs E. W. West

Address: Delmar Del.

17. Burial (Burial, ~~cremation, or removal~~, Which?) Date thereof: 1-2-46 (month) (day) (year)

Cemetery or ~~crematory~~: M. P.

Location: Delmar, Del

18. Funeral director: G. S. Mann Co

Address: Delmar, Del

19. Jan 2 1946 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 30 1945 at 6 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 1 1944 to Dec 30 1945 and that I last saw him alive on Dec 30 1945

	DURATION
Immediate cause of death: Cardiac Failure	
Due to: Senile Arthritis following Cerebral Thrombosis	1 yr
Due to: Chronic Bronchitis	Several Months
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. H. Ford M. D. or other

Address: Delmar Del Date signed: Jan 12 46

VS A15 9.45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Gray

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

12866

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred: 901. E. Church St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 901. E. Church St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Sarah Priscilla Whayland

3. (b) Social Security Number:

4. ~~Color or race~~: White
5. ~~Single, married, widowed, or divorced~~: Female
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Charles Thomas Whayland
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): March 15- 1868
8. AGE: Years: 77 Months: 9 Days: 11 If less than one day: hrs. min.
9. Birthplace: Siloam Maryland (Town, county, and state)
10. Usual occupation: Home Wife
11. Industry or business: at Home
FATHER 12. Name: Warren Bruntley
FATHER 13. Birthplace: Siloam Md.
MOTHER 14. Maiden name: Mrs. Record
MOTHER 15. Birthplace:
16. Informant: Mrs. George Taylor
Address: R.D. #3 Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 29-45 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland
18. Funeral director: Holloway & Lelly Md.
Address: Salisbury Md.
19. 12/29/1945 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 26 1945 at 3308 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1 1945 to Dec 26 1945
and that I last saw h... alive on December 26 1945

	DURATION
Immediate cause of death: Pneumonia	
Due to: Arteriosclerotic C-V-R Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Dr. H. Gray M. D. or other
Address: Salisbury Md. Date signed 12/28/45

(M)

MARGIN RESERVED FOR BINDING

(I)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (54)

CERTIFICATE OF DEATH

12867

Reg. Diat. No. 229

1. PLACE OF DEATH:

County: Wicomico

City or town: Pittsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: ✓

How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Pittsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. ✓ Rural.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Annie Mae White

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Arthur White

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Nov. 15, 1890

8. AGE: Years: 55 | Months: | Days: | If less than one day: ____ hrs. ____ min.

9. Birthplace: Wicomico, Md. (Town, county, and state)

10. Usual occupation: Invalid

11. Industry or business:

FATHER — 12. Name: Geo. W. "Calloway"

13. Birthplace: Md.

MOTHER — 14. Maiden name: Clorcey Turner

15. Birthplace: Md.

16. Informant: John Calloway

Address: Willards. Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 23, 1945 (month) (day) (year)

Cemetery or crematory: Fairlawn Cemetery

Location: Pittsville Md.

18. Funeral director: M. Pasha Watson

Address: Salisbury, Md.

19. 12/23/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 21 1945 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to Day of death and that I last saw her alive on Nov 30, 1945.

Immediate cause of death	DURATION
Rheumatic heart disease	16 yrs.
Due to	
Due to Rheumatic fever	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: Grant K. Lewis M.D. M. D. or other

Address: Salisbury Md. Date signed 12-22-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12868

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH:
County: Worcester
City or town: Wetipquin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: R.D. Quantico Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Worcester
City or town: Quantico
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Munsey Putman White

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ethel White

6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): Aug. 1- 1886

8. AGE: Years	Months	Days	If less than one day
59	4	8	....hrs. ....min.

9. Birthplace: Wetipquin Maryland
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:

FATHER
12. Name: Noah Henry White
13. Birthplace: Wetipquin Maryland

MOTHER
14. Maiden name: Mary Jane Adams
15. Birthplace: Dorchester Co. Maryland

16. Informant: Mr. Bloomfield White (Brother)
Address: R.D. Quantico Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 11-1945 (month) (day) (year)
Cemetery or crematory: White Family Cem.
Location: Bloomfield White Farm Wetipquin Md

18. Funeral director: C. E. Murrick
Address: Pisalore Md

19. Dec. 11 1945 (Date rec'd by registrar) K. Woolford Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 9th 1945 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 2d 1945 to Dec. 9th 1945 and that I last saw him alive on Dec. 9th 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William Emrich M. D. or other
Address: Hebron Md Date signed: Dec. 11 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12869

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 11/6/45

Hospital, institution, or street address where death occurred:

Eastern Shore Tuberculosis Sanatorium

How long in hospital or institution? Since 11/6/45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Berlin

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: No ✓

3.(a) FULL NAME: Whitman, Albert Leslie

3.(b) Social Security Number: 212-16-1941

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 3, 1909

8. AGE: Years	Months	Days	If less than one day
36	2	16	hrs. min.

9. Birthplace: Northhampton, Virginia (Town, county, and state)

10. Usual occupation: Serv. Station Attendant

11. Industry or business

FATHER — 12. Name: George Whitman

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Lillian Lank

15. Birthplace: Maryland

16. Informant: self

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/23/45 (month) (day) (year)

Cemetery or crematory: Bowers

Location: Newark Md

18. Funeral director: Bunn A. Bunbage

Address: Berlin Md.

19. 12/29/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 19 1945, at 10:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 6 1945 to Dec. 19 1945 and that I last saw him alive on Dec. 19 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paul Ow M. D. or other

Address: Snow Hill, Maryland Date signed: 12/20/45

M

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VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12893

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Mo. 23 Da

Hospital, Institution, or street address where death occurred:
Peninsula General Hosp.

How long in hospital or institution? 1 Mo. 23 Da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt 2
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Baby Boy James ~~Henry~~ Williams

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	

B.(b) Name of husband or wife

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1945

8. AGE:

Years	Months	Days	If less than one day
	1	23	..... hrs. ..... min.

9. Birthplace (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name James C. Williams

13. Birthplace Unknown

MOTHER 14. Maiden name Beatrice Gunby

15. Birthplace Philadelphia

16. Informant

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/30/45 (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director Grandfather - Roger B. Gunby (acting)

Address Berlin, Md

19. 12/30 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29 19 45 at 2 45 P.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 7 19 45, to Dec 29 19 45

and that I last saw him alive on Dec 28 19

Immediate cause of death Premature birth — DURATION: births

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

20. SIGNATURE J. E. Timmons M.D.
M. D. or other

Address Salisbury, Md Date signed Dec 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-2)

12870

CERTIFICATE OF DEATH

Reg. Dist. No. 283

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 8 years
Hospital, Institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Wicomico
City or town Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 114 Welt
(If rural, give LOCATION)
2.(a) If veteran, name war no

3.(a) FULL NAME John H williams

3.(b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a.a.	Married

8.(b) Name of husband or wife Annie Williams
yes 8.(c) If alive, give age Won't know years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
about 63			hrs. min.

9. Birthplace Somerset County (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Same as above
FATHER 12. Name Unknown
FATHER 13. Birthplace Unknown
MOTHER 14. Maiden name Unknown
MOTHER 15. Birthplace Unknown
16. Informant Mrs. Annie Williams
Address Salisbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 9-1945 (month) (day) (year)
Cemetery or crematory Somers Cemetery
Location Somers County and
18. Funeral director James A. Stewart
Address Salisbury Md
19. 12/9 1945 H. Harriet E. Johnson Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-6-1945 at 1 20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-5 1945 to 12-5 1945 and that I last saw h alive on 12-5-45 1945

Immediate cause of death	DURATION
Asphyxia	
Due to Cardiac Asthma	2 weeks
Due to Left ventricular failure	
Resulting from Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E. A. Purnell M.D. M. D. or other
Address 800 W. Main St Date signed 12-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131(a)

CERTIFICATE OF DEATH

File No. 1287 Reg. Dist. No. 133

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred: 321. Race Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants, give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 321. Race Street (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Grace Lavenia Wilson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: George Wilson
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): No Record

8. AGE: Years: one | Months: 75 | Days: years | If less than one day: hrs. min.

9. Birthplace: Salisbury Maryland (Town, county, and state)
10. Usual occupation: at Home
11. Industry or business:

FATHER
12. Name: Wade Hastings
13. Birthplace: Wicomico Co. Md.

MOTHER
14. Maiden name: Grace
15. Birthplace: Wicomico Co. Md

16. Informant: Mrs. Lula Wallace
Address: 1103 Green St. Marion Station Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 1-1946 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland

19. 1/1/46 (Date rec'd by registrar) Maggie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 28 1945 at 6.20p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 10 1945, to Dec. 28 1945 and that I last saw h[er] alive on Dec. 28 1945

Immediate cause of death	DURATION
Myocarditis	
septicemia, bed sores.	
Due to: Chronic interstitial nephritis; duration, unknown.	
Chronic myocarditis; duration, unknown.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Newsome Jr. M. D. or other
Address: Salisbury Md Date signed: 12/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15